# EXHIBIT 1

**UNITED STATES DISTRICT COURT**
**DISTRICT OF MASSACHUSETTS**

| | |
|---|---|
| IN RE: NEW ENGLAND COMPOUNDING PHARMACY, INC. PRODUCTS LIABILITY LITIGATION | MDL No. 1:13-md-02419 |
| THIS DOCUMENT RELATES TO:<br><br>Plaintiff: _____ | Hon. F. Dennis Saylor, IV |

PLAINTIFF'S PROFILE FORM

Plaintiff, through counsel, files the following Profile Form:

## I. CASE INFORMATION

1. Name of person on whose behalf a claim is being made (first, middle name or initial, last), including maiden or other names used:

   a. Were you (or the person identified above) administered the steroid methylprednisolone acetate?

   ☐ Yes ☐ No ☐ Do Not Know

   b. Were you (or the person identified above) administered another NECC Product?

   ☐ Yes ☐ No ☐ Do Not Know

   If yes, please identify: _____

2. Name of person signing this form, if different from above:

   _____

   a. Relationship of signer to party on behalf of whom claim is being made (such as spouse, parent, family member, adult child, guardian):

   b. If the person completing this Fact Sheet is completing this questionnaire in a representative capacity (*e.g.*, on behalf of the estate of a deceased person or a minor) ("Representative"), please complete the following:

      1. Representative's Social Security Number (***Last 4 digits ONLY***):

         XXX-XX-_____.

2. Maiden or other names used or by which Representative has been known:

_____

Address:

_____

_____

3. State which individual or estate the Representative is representing, and in what capacity the Representative is representing the individual or estate (guardian, administrator, executor, etc.)?

_____

4. If appointed as a Representative by a court, please identify the court:

_____

Date of Appointment: _____

5. What is the familial or other relationship between the Representative and the deceased or represented person, or person claimed to be injured?

_____

6. If the Representative is representing a decedent's estate, please state the date of death, the address where the decedent died, and the cause of death and attach a copy of the death certificate if available:

_____

_____

3. Please check the injuries you sustained as a result of exposure to the NECC Product(s):

☐ Death

☐ Fungal Meningitis

☐ Arachnoiditis (persistent nerve pain)

☐ Phlegmon (persistent nerve pain at base of spine)

☐ Osteomyelitis (infection in bone, including vertebral or diskitis)

☐ Sacroiliitis (pain at base of spine)

☐ Peripheral Joint Pain (at site of injection)

☐ Septic Arthritis

☐ Epidural Abscess

☐ Stroke or stroke like symptoms (Cerebral Vascular Accident)

☐ Lumbar Puncture (Spinal Tap), Subsequent Treatment

☐ Lumbar Puncture (Spinal Tap), No Subsequent Treatment

☐ Infection of any kind, describe if known: _____

☐ Injection only, no symptoms or treatment

☐ Other (describe): _____

(Attach additional sheets if necessary to describe.)

_____

Identify each address at which you have resided since January 1, 2009, and list when you started and stopped living at each one:

| Address | Dates of Residence |
|---|---|
| | |
| | |
| | |
| | |
| | |

## II. EMPLOYMENT INFORMATION

4. Are you making a claim for lost wages or lost earning capacity: ☐ Yes ☐ No

If you answered "Yes," please provide:

The total amount of income you claim to have lost as a result of injuries you associate with your exposure to the NECC Product:
_____ if ongoing, please so state.

Current employer and all prior employers, from 1/1/2008 to the present:

| Name | Address | Dates of Employment | Occupation/Job Title |
|---|---|---|---|
| | | | |

## III. INSURANCE/DISABILITY

5. Have you been awarded Social Security Disability benefits? If so, state the year of the award and the nature of the disability: _____

6. Have you received a worker's compensation award since January 1, 2004? ☐ Yes ☐ No. If you answered "Yes," to the best of your knowledge please state:

   Year claim was awarded: _____, Nature of the claim: _____

7. Did you have medical insurance for treatment rendered?

   [ ] Yes [ ] No

   a. If yes, please provide the following information for each insurance company. If more than one, please provide information for all:
   Name of Health Insurance: _____

   Policy No.: _____

   Name of Subscriber: _____

   b. If you have Medicare or Medicaid coverage, please state your ID number: _____

   c. Has any insurance company asserted a lien on your recovery? [ ] Yes [ ] No

   If yes, please provide the name of the lienholder: _____

## IV. BACKGROUND AND FAMILY INFORMATION

8. Identify the highest level of education (high school, college, university or other educational institution) you have attended (even if not completed), the dates of attendance and diplomas or degrees awarded:

| Institution | Dates Attended | Date of Graduation | Diplomas or Degrees |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

9. As an adult, have you been convicted or plead guilty to a felony or a crime of fraud, dishonesty, or moral turpitude in the past ten years? ☐ Yes ☐ No If you answered "Yes," describe where, when and the felony and/or crime. _____

_____

_____

_____

10. Are you married? ☐ Yes ☐ No

List the name of your spouse; and the date of marriage:

_____

_____

_____

11. If applicable, for each of your children, list his/her name and age :

_____

_____

_____

_____

_____

12. Have you ever served in the military, including the military reserve or national guard?

☐ Yes ☐ No

If you answered "Yes," answer the following question: Were you ever dishonorably discharged from military service?

☐ Yes ☐ No

## V. MEDICAL INFORMATION

13. Date(s) you were administered or used an NECC Product:

_____

14. Hospital/clinic*I*physician's office where you were administered the NECC Product:

Name:_____

Full Address:

_____
_____
_____

15. Physician(s) who administered the NECC Product:

Name: _____

Full Address:

_____
_____
_____

16. What medical condition(s) did you have for which you were treated with the NECC Product (for example, osteoarthritis, back injury, etc.)?

_____

17. Identify your treating physician for the condition(s) in the preceding question if that physician is different from the one who administered the NECC Product:

Name: _____

Full Address: _____
_____

18. Are you claiming mental and/or emotional damages as a consequence of exposure to the NECC Product?

☐ Yes ☐ No If you answered "Yes to #___," and if you received any type of medical care for such condition, list any provider (such as a primary care physician, psychiatrist, psychologist, counselor, or therapist) from whom you have sought treatment for any emotional condition, from 2012 until the present: _____

The condition(s) for which you were treated: _____

_____

_____

19. If you are making a claim for emotional damages, and you received medical care prior to having received any NECC recalled product, state the condition and the medical provider(s): _____

_____

_____

_____

## VI. MEDICAL BACKGROUND

20. What is your height? _____; What is your weight____

21. Smoking/Tobacco Use History: Do you currently use tobacco products? ___ Yes __No. If yes, for how long: _____.

22. Have you been diagnosed with HIV/AIDS, Lupus, Inflammatory Bowel Syndrome, Crohn's disease, and/or ulcerative colitisat any time from January 1, 2004 to the present? ☐ Yes ☐ No __ Don't know. If you answered "Yes," provide the following information:

| Condition | Date Diagnosed | Diagnosing Physician | |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

23. To the best of your knowledge, during the past five years, have you been diagnosed with:

| | | Yes | No | Don't Know |
|---|---|---|---|---|
| a. | Myocardial infarction (MI) or heart attack, | ___ | ___ | ___ |
| b. | Hypertension | ___ | ___ | ___ |
| c. | Stroke | ___ | ___ | ___ |
| d. | Diabetes | ___ | ___ | ___ |
| e. | Cirrhosis | ___ | ___ | ___ |
| f. | Congestive heart failure | ___ | ___ | ___ |
| g. | Hepatitis | ___ | ___ | ___ |

| | | Yes | No | Don't Know |
|---|---|---|---|---|
| h. | Chronic obstructive pulmonary disease (COPD) | ___ | ___ | ___ |
| i. | Arteriosclerosis | ___ | ___ | ___ |
| j. | Kidney Failure-Acute Renal Failure, ESRD | | | |

24. Please list each hospitalization you have had since January 1, 2009 (if any):

| Date | Name of Hospital | Reason for Hospitalization |
|---|---|---|
| | | |
| | | |
| | | |
| | | |

## VII. LIST OF MEDICAL PROVIDERS AND OTHER SOURCES OF INFORMATION

25. List the name and address of each of the following:

26. To the best of your ability, identify each primary care physician as well as any doctor you have been treated by since January 1, 2009:

| Name | Address | Approximate Treatment Dates |
|---|---|---|
| | | |
| | | |
| | | |

27. List each hospital, clinic, health care facility, or health care provider where you have received outpatient treatment (including treatment in an emergency room) since January 1, 2009:

| Name | Address | Admission Dates | Reason for Admission |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |

28. List each pharmacy that has dispensed medication to you since your exposure to the recalled product(s):

| Name | Address |
|---|---|
| | |
| | |
| | |
| | |

## VII. DOCUMENTS

Please produce any of the following documents and things that are currently in your possession, custody, or control, or in the possession, custody, or control of your lawyers. Please attach all non-privileged documents and things to your responses to this Fact Sheet.

1. If this Profile Form was completed by a Representative, any court paper that authorizes the stated Representative to act on behalf of the person claiming injury.

2. Death certificate, if applicable, as requested above.

## IX. VERIFICATION

I declare that the information provided in this Plaintiff's Fact Sheet is true and correct to the best of my knowledge, information and belief, that I have supplied all the documents requested in this Plaintiff's Fact Sheet, as required above.

Signature:

_____

Print or Type Name:

_____